MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

# ENTRY OF APPEARANCE

3315 West Truman Blvd.
P.O. Box 58
Jefferson City, MO 65102-0058

_____, )
Health Care Provider, )
)
vs. )
)
_____, )
Employer, )
)
and )
)
_____, )
Insurer )

Medical Fee Dispute No: ____ - _____

Injury No.: ____ - _____

Employee (Patient): _____

Date of Accident/
Occupational Disease: _____

## ENTRY OF APPEARANCE

COMES NOW, _____ attorney at law & hereby enters his/her appearance on behalf of:

☐ Health Care Provider

Name _____

☐ Employer

Name _____

☐ Insurer/Third Party Administrator

Name _____

Respectfully submitted, _____

Name of Attorney _____

Law Firm _____

Address _____

Bar No. _____

Phone No. _____

Fax No. _____

E-mail Address _____

## CERTIFICATE OF SERVICE

I, the undersigned, certify that, a copy of this Entry of Appearance has been mailed or hand delivered to all attorneys and/or all parties of record this _____ day of _____, 20____.

Attorney's Signature _____ Date _____

Attorney's Name *(Printed)* _____ Bar No. _____

Address *(if different than above)* _____

DIVISION USE ONLY

DATE STAMP